AGA ASSURANCES COLLECTIVES

**INFORMATION DRUG REQUEST**
**BIOLOGIC DRUGS**

## SECTION 1 – INFORMATION ON THE MEMBER

| | | |
|---|---|---|
| Member name: | Group number: | Certificate number: |
| Address (No. / Street / Apt.): | | |
| City : | Province : | Postal Code : |
| Phone number : | E-mail address : | |
| Employer name / Policy holder: : | Division number: | |

## SECTION 2 – INFORMATION ON THE PATIENT

Patient name:

| | |
|---|---|
| Patient Date of Birth (YYYY/MM/DD): | Relationship to member: |

Have you applied for coverage with a provincial program? ☐ YES ☐ NO

Has your application for coverage with the provincial program for this drug or supply been approved? ☐ YES ☐ NO

If you have applied for coverage with a provincial program, please provide us with a copy of the refusal or acceptance letter.

Are you enrolled in a drug manufacturer's patient assistance program? ☐ YES ☐ NO

If yes, please provide your patient assistance program identification number: _____

## SECTION 3 - AUTHORIZATION TO SHARE PERSONAL INFORMATION

**I authorize any health professional (doctor, pharmacist, dentist), any person (service provider), any other insurance company, any public or private health institution, any government agency in relation to health or social services, to disclose and exchange requested information by the insurer or AGA Benefits Solutions, necessary for the evaluation of my request for prior authorization for that drug.**

| | |
|---|---|
| Patient signature: | Date: |
| Signature of the subscriber when patient is a minor: | Date: |

## SECTION 4 - DRUG COVERED BY THE APPLICATION

Biologic Drug Name:

Dosage:

| | |
|---|---|
| Pharmaceutical Form: | Content / Strength: |

Anticipated duration of treatment: From (YYYY/MM/DD) : To (YYYY/MM/DD) :

| | |
|---|---|
| Diagnosis: | Initial date of diagnosis (YYYY-MM-DD): |

Medication will be administered at the following location:

☐ Home ☐ Health an social service center ☐ Long-term care center ☐ Private clinic

☐ Hospital - internal patient ☐ Hospital - external patient ☐ Elsewhere. Specify : _____

If the treatment is not administered at home, please provide the following information:

| | | | |
|---|---|---|---|
| Name of the location where the drug will be administered: | | Telephone: | |
| Address (No. / Street / Apt.): | City : | Province: | Postal Code : |

## SECTION 5 - TYPE OF APPLICATION

| | | |
|---|---|---|
| ☐ Initial request | ☐ Continued treatment | ☐ Modification of treatment |

*Continue to page 2*

## SECTION 6- SUMMARY OF PREVIOUS TRIALS OR CONTRAINDICATIONS

Please provide a list of medicines and/or treatments used to date to control this condition:

| Name of drug/treatment currently or previously prescribed | Content - strength / Dosage | Trial Period | | Reason for Discontinuation |
|---|---|---|---|---|
| | | From (YYYY-MM-DD) | To (YYYY-MM-DD) | |
| | | | | ☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify: |
| | | | | ☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify: |
| | | | | ☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify: |
| | | | | ☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify: |
| | | | | ☐ Allergy ☐ Intolerance ☐ Ineffective ☐ Relapse ☐ Other Specify: |

## SECTION 7 - GENERAL CLINICAL INFORMATION

**Please specify the reason the patient cannot switch to a biosimilar version of the reference biologic drug:**

☐ Pregnant woman, including 12 months following birth

☐ People under 18 years of age, for the rest of the present authorization up to a maximum of 12 months following the 18th birthday

☐ People with treatment failure to at least 2 other biologic drugs used for the same medical condition

## SECTION 8 - CLINICAL INFORMATION SPECIFIC TO NOVORAPID

Please precise if Novorapid has been started before February 2, 2022?

☐ Yes, please provide us a proof of purchase.

☐ No

## SECTION 9 - CLINICAL INFORMATION SPECIFIC TO HUMALOG

Please precise if Humalog has been started before March 3, 2021?

☐ Yes, please provide us a proof of purchase.

☐ No

Does the patient use an insulin pump? ☐ Yes ☐ No

## SECTION 10– ADDITIONAL INFORMATION (optional)

## SECTION 11 – SIGNATURE OF AUTHORIZED PRESCRIBER

| | | |
|---|---|---|
| Print name of authorized prescriber: | Specialty of the physician: | |
| Signature of authorized prescriber: | License Number: | Date : |

## SECTION 12 - IMPORTANT PATIENT INFORMATION

Fees may be charged to complete this form, it is the patient's responsibility to pay them.
Ensure all required sections of the form have been completed and signed before returning it.
Attach any additional documents required on this form.
Your request may be delayed if we do not have all the necessary information.
The drug will be eligible only if it meets the criteria established by the insurer.

## HOW TO RETURN THE FORM

| | |
|---|---|
| By fax: (514) 935-1147<br>By email: exceptions@aga.ca | By mail : AGA Benefit Solutions<br>3500 de Maisonneuve Blvd. W, suite 2200<br>Westmount (QC) H3Z 3C1 |